PLEDGE FORM

I/We would like to make a total contribution of $_____to the ICCHA/Wish Fund over __ years

DONOR INFORMATION

Name

Address

City

Province | Postal Code

Cell Number | Other Number (specify)

Email Address

RECOGNITION

Name to appear on donor listings

☐ I wish to remain anonymous

☐ Further discussion required to finalize

What is your preferred communication method?

PAYMENT OPTIONS

My first payment will be made on ___/___/____
DD MM YY

My payment will be made:

☐ One time in full ☐ Annually

☐ Monthly ☐ Other _____

☐ **Cheque** (payable to Royal Inland Hospital Foundation)

Cheque enclosed in amount of $_____

Post-dated cheques in amount of $_____

Void cheque enclosed (monthly amount) $_____

☐ **Credit Card**

Payment in the amount of $_____

Visa ☐ Mastercard ☐

Card Number | Expiry

Cardholder Name

Cardholder Signature

THANK YOU FOR YOUR SUPPORT!

An official tax receipt will be issued for your gift once received. Royal Inland Hospital Foundation personnel respect your privacy. Our staff will always ensure that all donor information is held in strict confidence in accordance with all privacy legislations.

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